The CANADIAN HOSPITAL

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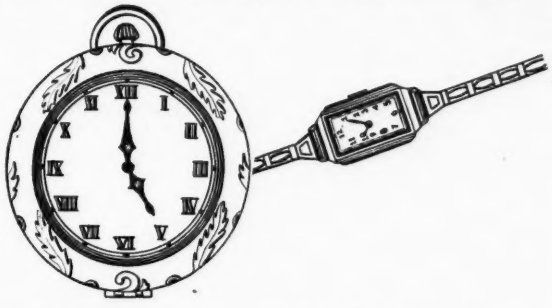
1937

Official Journal
CANADIAN HOSPITAL COUNCIL

AS WITH ALL FINE INSTRUMENTS



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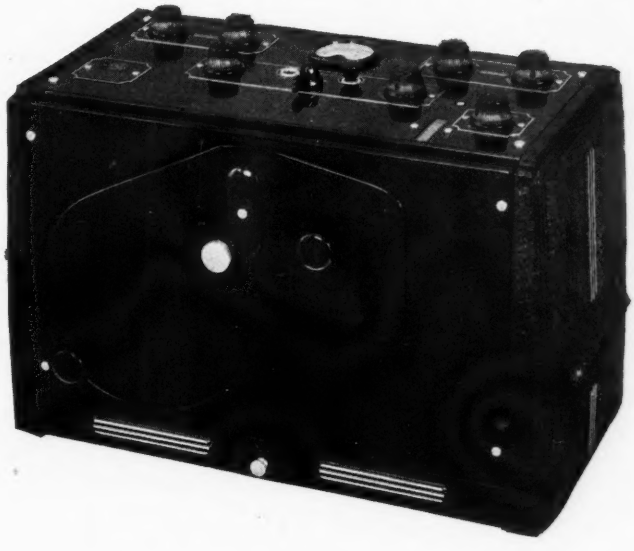

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CONTENTS

INDEX TO ADVERTISERS

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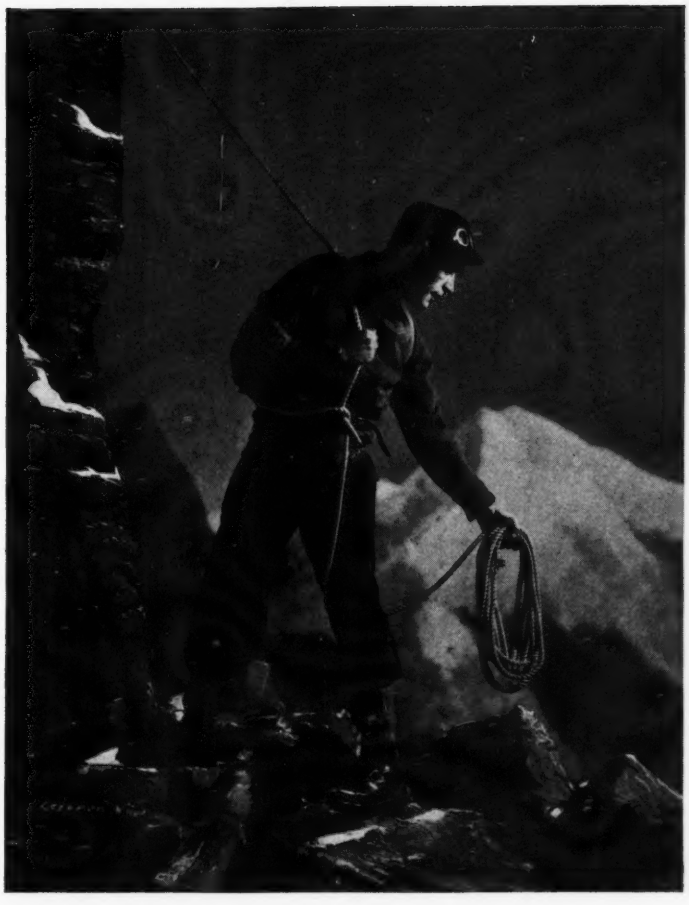

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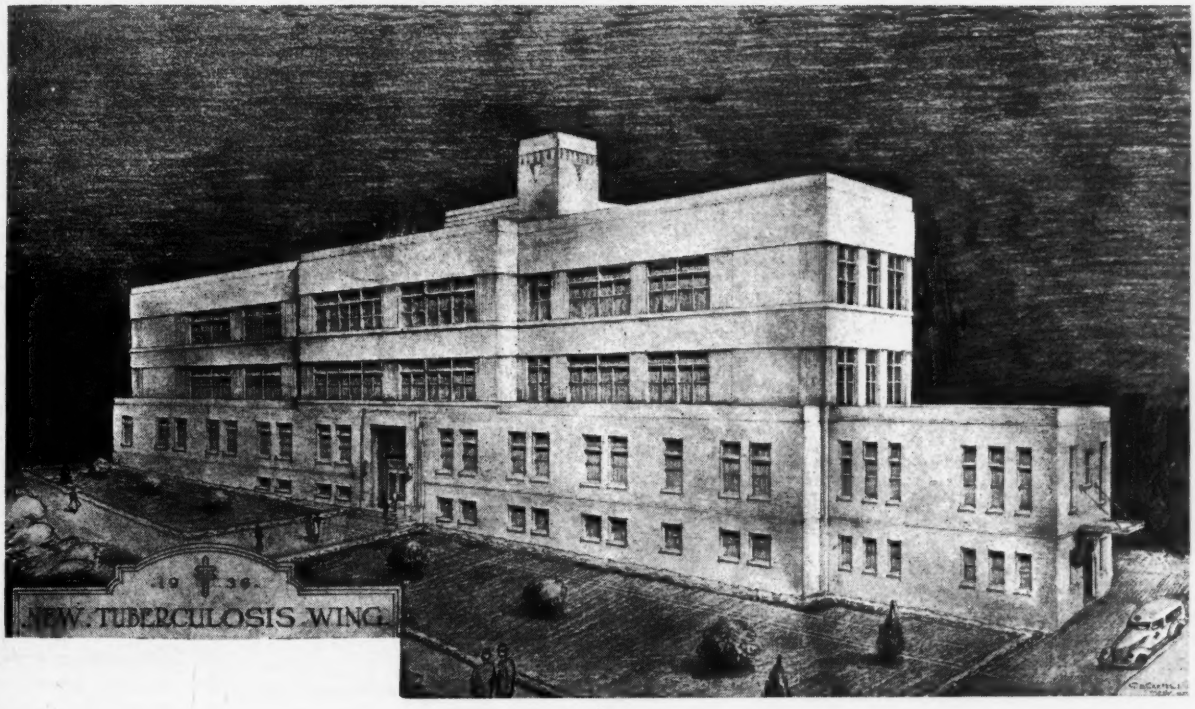


Figure 1.
The New Tuberculosis Unit of the Provincial Board of Health, British Columbia.

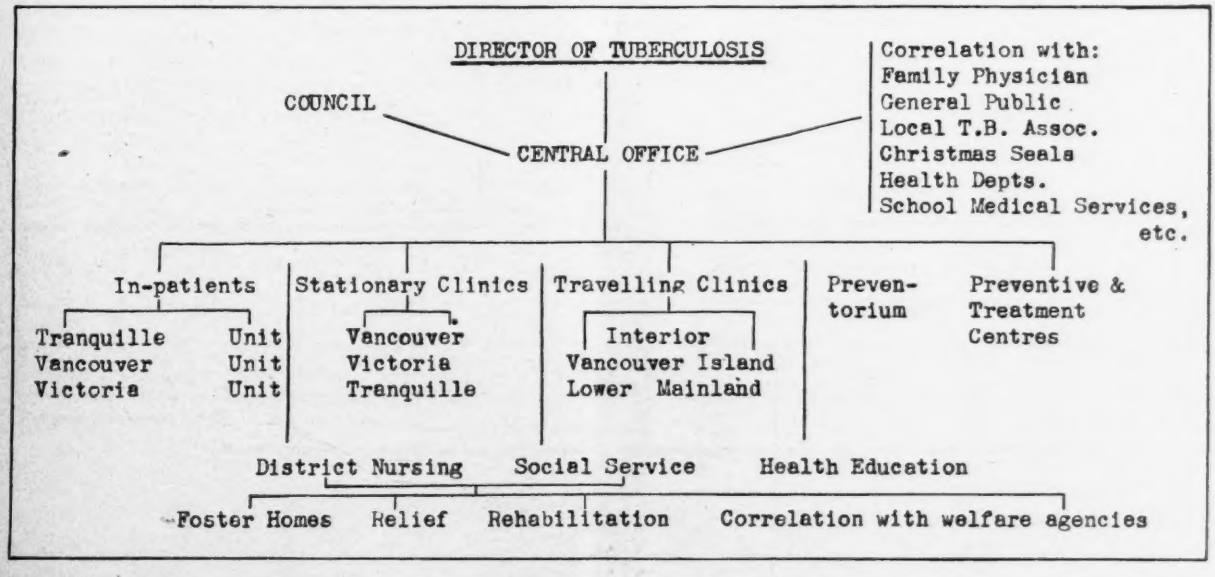
The New Tuberculosis Unit of the Provincial Board of Health, British Columbia

By W. H. HATFIELD, M.D.,
Director of Tuberculosis Control, Provincial Board of Health, British Columbia.

IN 1935 there was instituted in British Columbia what is known as the Tuberculosis Division of the Provincial Board of Health. This new Division took over all the existing facilities in the whole Province for the diagnosis, treatment, and prevention of tuberculosis, including sanatoria, hospital beds, clinics (stationary and travelling), social service, district nursing, etc.

The Organization Plan

In the eighteen months since this organization was started there has been developed a comprehensive plan for



the diagnosis, treatment, and prevention of tuberculosis. The present set-up of the organization is depicted on page preceding.

Many new developments have taken place, such as:

Increased bed facilities in several centres.

Increased travelling clinics, so that every centre in the Province is served regularly.

Development of what are termed Preventive and Treatment Centres, to serve the scattered areas of the Province.

Opening of a Convalescent Home.

Standardization of records in all clinics and institutions.

Application of the punch-card method for all records.

Establishment of a Central Office, to which all cases in the Province are reported, and through which all cases are admitted to the various institutions.

Development of a Provincial Social Service Department and District Nursing Department for the Tuberculosis Division.

Inauguration of a rehabilitation programme.

Institution of routine tuberculin testing in the schools throughout British Columbia.

Organization of a B.C. Tuberculosis Society for lay people which publishes a journal monthly.

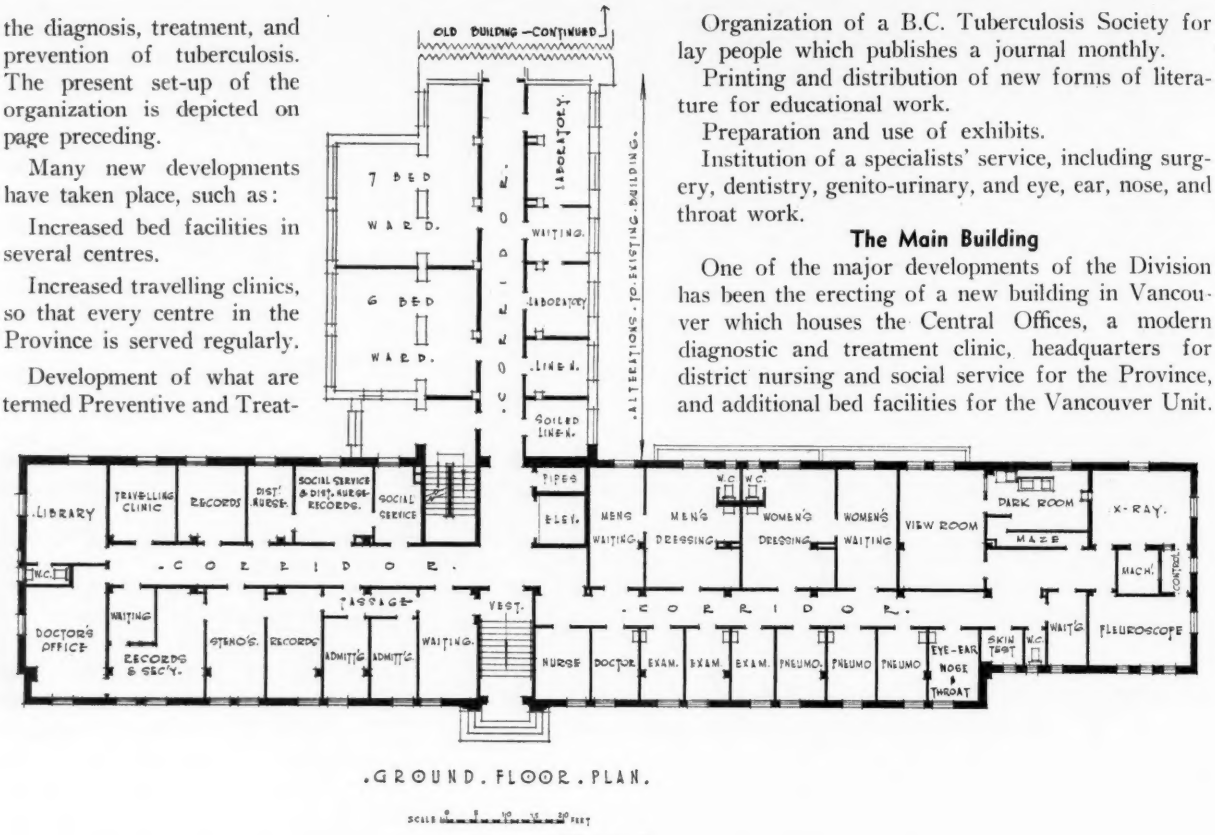
Printing and distribution of new forms of literature for educational work.

Preparation and use of exhibits.

Institution of a specialists' service, including surgery, dentistry, genito-urinary, and eye, ear, nose, and throat work.

The Main Building

One of the major developments of the Division has been the erecting of a new building in Vancouver which houses the Central Offices, a modern diagnostic and treatment clinic, headquarters for district nursing and social service for the Province, and additional bed facilities for the Vancouver Unit.

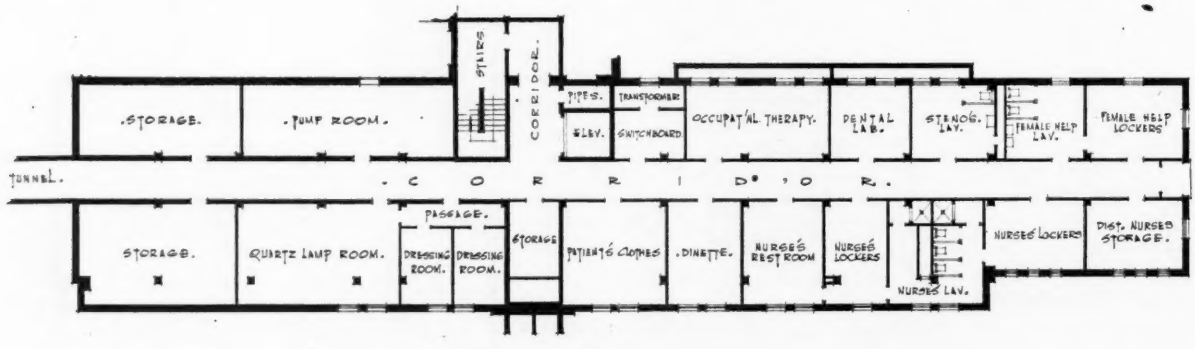


.GROUND. FLOOR. PLAN.

SCALE 0 5 10 15 20 FEET

Figure 2.

This new building is the hub of the whole anti-tuberculosis work for the Province. Every new case of tuberculosis discovered in British Columbia is reported here. From here radiate the Social Service and District Nursing Departments, Lower Mainland and Coast Travelling Clinic, and to the Vancouver Clinic at the present time approximately 1,000 patients come each month for diagnosis and treatment. Two physicians are also working at this unit on fellowships. All cases needing institutionalization send their applications to the Central Headquarters and are allotted to a particular unit, depending upon their social condition and physical condition. Here are provided up-to-date laboratory service, in-patient and out-patient dentistry, in-patient and out-patient eye, ear, nose, and throat service, quartz lamp treatments, etc. The building



.BASEMENT. PLAN.

Figure 3.

is situated in the heart of Vancouver, thus servicing approximately 50% of the population of the whole Province. It was built and equipped and is maintained by the Provincial Government. It is built with four storeys and a roof garden, and is of reinforced concrete, designed along modernistic lines (Fig. 1). The occompanying illustrations of the floor plans give quite clearly the layout of this building, and indicate how the services are correlated and the type of service which is rendered.

The Record Office

The ground floor plan is the one of particular interest (Fig. 2). One end is given over largely to administration and records. The Central Record Office receives reports from all units in the Province daily, including the institutions and the other stationary and travelling clinics. Every new case of tuberculosis is reported here and properly recorded. At the present time this office has 4,157 known cases of tuberculosis. This is a ratio of 7.02 known cases for each death for the whole Province. The Province is then divided into statistical areas, and the ratio of known cases to death and new cases to death for each statistical area is kept separate, so that it is possible to see which area is lagging behind. The average ratio of new cases to deaths, reported monthly, is 2.43. Every new case of tuberculosis is reported in detail on a statistical form to the central office and is there checked. These records are then all sent to the vital statistics branch in Victoria, where everything is placed on punch-cards, so that all material is readily available for analysis at any given moment, either from an administrative or a scientific viewpoint. Each month the central record office puts out a monthly bulletin describing the work of each unit in the Province in detail giving a statistical summary of all work done; also graphs of the death rates, ratio of new cases to death, number of new cases monthly and other information to give a complete picture of the tuberculosis problem for that month as it pertains to the whole of British Columbia.

Admissions

The central office also acts as an admitting office for the whole Province. Any new case of tuberculosis applies for admission from anywhere to this office, and is then allocated to the particular institution where it is felt that this case should go, the decision hingeing upon the patient's physical condition and social status. Adjacent to the record office will be seen quarters for Provincial Social Service and District Nursing. There is a provincial supervisor for District Nursing and a provincial supervisor for Social Service. Every new application received at the Central Office is sent to the District Nursing and Social Service office for a combined report of the public health aspect and of the social status of the patient. This is available on admission to whatever unit the patient goes. Again, on discharge from an institution a report is asked for from this office, and no patient is discharged until it is definitely known that the home conditions will be satisfactory, both from a public health and social standpoint. One of the travelling clinics, namely the one which covers the Lower Mainland and Coast, also has headquarters adjacent to the record department.

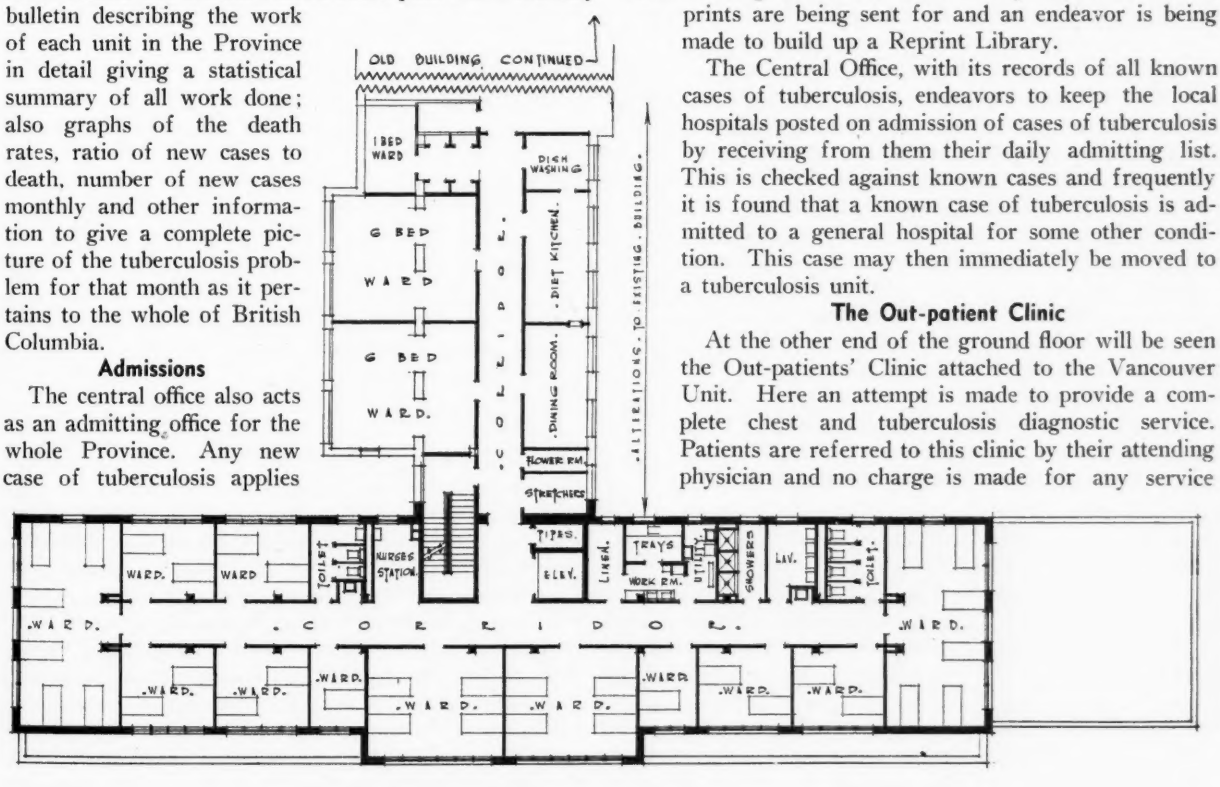
Medical Library

At one end will be seen the Doctors' Library and all available new literature is obtained and an attempt is made to keep this library as up-to-date as possible. Each doctor on the service throughout the Province is provided with a subscription to a medical journal and is obliged to abstract this journal and send his abstracts to the central office each month. The central office then compiles this into an Abstract Bulletin and forwards this to each doctor on the service monthly. Many other doctors throughout the Province have become interested in this, and this bulletin is being distributed more widely each month. Reprints are being sent for and an endeavor is being made to build up a Reprint Library.

The Central Office, with its records of all known cases of tuberculosis, endeavors to keep the local hospitals posted on admission of cases of tuberculosis by receiving from them their daily admitting list. This is checked against known cases and frequently it is found that a known case of tuberculosis is admitted to a general hospital for some other condition. This case may then immediately be moved to a tuberculosis unit.

The Out-patient Clinic

At the other end of the ground floor will be seen the Out-patients' Clinic attached to the Vancouver Unit. Here an attempt is made to provide a complete chest and tuberculosis diagnostic service. Patients are referred to this clinic by their attending physician and no charge is made for any service



.FIRST. FLOOR. PLAN.

Figure 4.

rendered. An attempt is made to have patients come by appointment and approximately 1,000 patients per month are seen. A complete medical staff, paid by the Tuberculosis Division of the Provincial Board of Health is available to carry out this work. Besides chest diagnoses there are eye, ear, nose, and throat, genito-urinary, dental and quartz-lamp services; other specialties are called in and paid for as necessary. Ample dressing rooms and waiting rooms are provided for the patients so that there is as little confusion as possible in the corridors. The dressing rooms are all cubiculed so that each patient may have his own dressing cubicule.

The View room, adjacent to the X-Ray room, has been made fairly large so as to allow conferences to be held there. Each week the conferences are attended by all the medical staff of the Tuberculosis Division at this Unit, and outside doctors are invited to attend and avail themselves frequently of the advice they are able to get at these conferences. The nurse and doctor in charge of the Clinic during each particular day, have an office in order to interview the many patients who need further advice. The examinations from a diagnostic standpoint are all carried out in the mornings, the treatments in the afternoons, thus the examination and pneumothorax rooms can be used interchangeably if necessary. Down the other corridor will be seen the main laboratory for routine work, carrying out laboratory diagnoses and laboratory prognostic work, for both in-patients and out-patients; the other laboratory available is being used at the present time for research work. Two fellowships are provided annually at the Vancouver Unit, and at the present time two fellowships are being carried on, on clinical laboratory lines.

Sub-floor Layout

The basement plan (Fig. 3) shows that every bit of space is made available. Two large storage rooms are used, one for storing crockery, linen, etc., the other for storing X-Ray films and hospital records. The quartz-lamp room is equipped to handle both in-patients and out-patients, and 200 patients per day can be treated in this room without any difficulty. Instead of the central quartz-lamp unit, the individual type of quartz-lamp is suspended from the ceiling, so that any unit of patients, one up to seventeen, can be treated at any given time. Adjacent to the quartz-lamp rooms are dressing rooms for male and female patients. Each patient has his own locker during the time that he is having treatment. The room labelled Occupational Therapy has now been changed to a Pathological Museum. Since the development of this building funds have become available for the erection of a complete Occupational Therapy Department. This new Occupational Therapy Department, termed the Vancouver Occupational Industries, will be immediately adjacent to the new building and will be equipped with two large work shops and a store for the sale of goods. The dental clinic is on this floor and out-patients may enter this floor for either dental work or quartz-lamp without going to the floor above. Space is available for nurses' lockers, nurses' rest room and for the other female help; comparable space for the orderlies is not seen in this building, as it is furnished in the old Unit. One other room of interest on this floor is the district nurses' storage room. The district nurse may drive her car to the door immediately adjacent to this room, and come here daily to receive supplies for use of the District such as: paper handkerchiefs, sputum cups, thermometers, bed pans, urinals, and other goods which are given by service clubs such as blankets, sheets, pyjamas, dressing gowns, slippers, medicines, etc.

Patient Service

The first-floor plan (Fig. 4) shows the layout of some of the wards of the building. The wards range in size from one bed to six beds, and an attempt has been made to give every facility combining this with cheerfulness. Each floor has been painted a different colour, and the beds on each floor are of a different colour, toning in with the colour of the walls. The throw-blankets on the beds of each floor also are of different colours. The floors have been tiled to add as much colour as possible. In all, every attempt has been made to give colour harmony throughout the building to produce the maximum benefit of a cheerful outlook. At each bedside, in addition to the ordinary facilities, there is a radio outlet. A central radio station is situated on the top floor of the building and can be used for tuning in outside stations, for playing gramophone records, or for broadcasting to the patients. The machine will also permit a two-way conversation between patient and broadcaster.

In all this Unit there is accommodation for 151 patients, plus the extensive facilities which are available for central office and diagnostic clinic. Immediately adjacent to this building is another building, the city isolation hospital, in which the Tuberculosis Division has taken over the top floor, which has complete operating room facilities. Here are housed the surgical tuberculous cases, giving therefore a complete surgical unit by itself.

Conclusion

It is felt that this new building fits in ideally to our widened vision of the tuberculosis problem as it exists in British Columbia. To-day we vision care of the in-patient as only one small part of the total problem. To-day British Columbia has 651 beds for the treatment of tuberculosis; this is 1.5 beds per death. It is felt that with an adequately functioning tuberculosis department this is sufficient, providing that we are able to establish an efficient District Nursing and Social Service Organization, which will allow us to discharge patients at the earliest possible moment. There has also been planned for the Province what might be termed a convalescent institution to house the far advanced, positive sputum case of tuberculosis who is able to be up and around for short periods and who needs no particular active treatment. In planning this building, the Tuberculosis Division has attempted to view the problem of tuberculosis in British Columbia as a whole, rendering service to as wide a portion of the community as possible. In order to do this the Central Office becomes an important feature in the development of the plan, for it is only through adequate functioning of this department that new cases of tuberculosis will be found in their earliest stages, and that all known cases of tuberculosis will be listed, so that there can be proper selection of admissions, discharges, and utilization of homes where possible. This building has only been in use for a short time, but more and more advantages are daily being seen from the association of the out-patients, the Central Office, the Bed Units; and looking upon the whole as one Unit of our Provincial program.

Canadian Hospital Council Executive Committee Holds Midwinter Meeting

Date of Biennial Meeting Set

THE mid-winter meeting of the Executive Committee of the Canadian Hospital Council was held in the secretarial office in Toronto, on March the 3rd. The following were present: Rev. Father Georges Verrault, Dr. F. W. Routley, Dr. A. F. Anderson, Rev. H. G. Wright and Dr. Harvey Agnew.

The President, Mr. W. R. Chenoweth, was unable to be present on account of illness, Father Verreault taking the chair.

Mr. C. A. Edwards, Business Manager of the Canadian Hospital, and Mr. N. S. Schatz, Solicitor, were present by invitation.

Incorporation of the Council

Steps leading up to the Incorporation of the Canadian Hospital Council were reviewed by Doctor Agnew, and by the Council Solicitor, Mr. N. S. Schatz. It was pointed out that, until such time as the incorporation of the Council and its revamped Constitution be presented to and accepted by the Council, the affairs of the Council are really in the hands of the officers of the unincorporated Council. Therefore, this present Executive Meeting is really a meeting of the Executive Committee of the old unincorporated Canadian Hospital Council, even though its personnel be identical with that of the Executive Committee of the incorporated Council. It was moved that the Executive Committee confirm its previous decisions and actions by mail ballot in connection with the incorporation and endorse all proceedings taken in connection therewith. Carried.

New Constitution

The Constitution of the incorporated Council will be presented for approval at the next general meeting of the Council. This varies in slight details from the present Constitution of the unincorporated Canadian Hospital Council. Certain changes in the new Constitution were proposed by the Executive Committee, and these will be submitted to the Constitution Committee for further consideration. These changes would facilitate the work of the Council, would permit better organization of the study committees, and would preserve the present democratic type of organization. Certain changes were suggested, which would clear up possible difficulties with respect to balloting or the holding of office under the original regulations. It was also proposed that the Second Vice-President should be added to the Executive Committee.

Canadian Hospital Journal

It was agreed that the Executive Committee express its satisfaction with the suitable arrangements made for the publication of the Canadian Hospital Journal by the Canadian Hospital Council Incorporated.

It was heartily agreed that the Executive Committee express its appreciation of the services of the Editor, Mr. Leonard Shaw; Dr. Harvey Agnew, the Secretary of the Council; the Editorial Board; and the Publication Committee.

The Business Manager presented an interim statement, which indicated a definite growth in advertising receipts; this, however, is being largely absorbed in additional expenses. With the completion of the first year a statement will be furnished every three months.

French Translations:

The lack of French articles and translations was deplored, but Father Verreault pointed out the difficulty of obtaining such. It was decided to continue as at present.

Editorial Board:

The personnel of the Editorial Board has been selected largely because of the individual member's ability and interest, having in mind geographical location, type of hospital, and other factors. It has been suggested, however, that women should be represented by an addition to the Editorial Board; such addition to the Board was endorsed by the committee.

Charge for the Journal:

The importance of increasing the revenue of the Council was emphasized, and it was agreed that a charge for the journal might be of material assistance. The journal goes free to every hospital in Canada, the larger hospitals receiving several copies, and a payment of $1.00 per year is voluntarily made by quite a number of the hospitals at the present time. It was felt by the Executive Committee that the majority of the hospitals would be perfectly willing to subscribe $2.00 a year for the Journal. Its quality has increased considerably during the past year, and the hospitals would be very willing to support their own publication. Of course, the journal would go to the hospitals anyway, a feature which would have to be emphasized in order to keep faith with the advertisers. The contribution would be on a voluntary basis. The proposal was referred with endorsation to the Publication Committee and the Editorial Board for further action.

Provincial Pages:

Doctor F. W. Routley announced that the Ontario Hospital Association has agreed to discontinue publication of its monthly bulletin, except for an annual meeting number, and to take a page for provincial news in the Canadian Hospital. This will be paid for at cost price, so that it will not encroach upon the general news space, which it was agreed would be limited to a fifty-fifty basis as compared to advertising when the agreement concerning the journal was made with the Edwards Publishing Company. (In view of the inability of the young Canadian Hospital Council to finance the immediate taking over of the Canadian Hospital, it was necessary to make this arangement, satisfactory to both sides, until such time, five years from the date of the agreement, when the Council can take over the journal entirely, if so desired.)

Any other association may take a page or half-page on the same basis. The point was raised that the Council would like to give each and every association as much space as it would like to take for its own local news items.

Many of these items now appear scattered here and there as major items or fillers throughout the journal. However, it was pointed out that, with the news space limited by the above ratio to the advertising obtained, it might readily be that news items from a dozen associations might encroach very badly upon the space now utilized for articles and contributions of general interest. It was finally agreed that all of the associations should be notified of this arrangement with the Ontario Hospital Association; that they should be asked the amount of space which they would be willing to promise to fill, without break, each month were no charge made. Upon receipt of such information the whole matter of local news allotments and any charges or otherwise could be reviewed by the Executive Committee, the Publication Committee and the Editorial Board.

Finance

An audited statement of the finances of the Council was presented by the Secretary-Treasurer. It was agreed that the Council should have further funds to supplement the support of the Department of Hospital Service of the Canadian Medical Association in carrying on the work of the Council. The work of the Council has grown tremendously since its organization, and its further development is being hampered by lack of funds to permit it to undertake various studies and activities not possible with the limited staff available. Various means of raising such funds were considered at length by the Executive Committee, and these will be taken up in due course with the associations.

Income Tax:

It was announced that the Canadian Hospital Council, being a charitable and educational organization, would not be subject to Income Tax.

Sales Tax

Exemption:

It was reported by one hospital that a certain large firm had endeavored to discontinue the exemption of hospital purchases from the Sales Tax exemption. This has since been adjusted to the satisfaction of the hospital. Hospitals would be well advised to check accounts carefully for this exemption.

Drugs:

The investigation of drug sales in two large hospitals by the Department of Internal Revenue was reported, and also the recommendations of the Commissioner of Excise that proper records of drug sales be kept and that periodic returns with remittances for taxable sales be made every three months.

Customs Tariff

Further discussion took place concerning the 10% tariff imposition upon non-British X-ray importations. It was noted that the Budget now before the Federal House does not propose any change in the existing arrangement. One installation of British equipment in Ontario was reported to the Executive. After considerable discussion, it was agreed that, at the next meeting of the Council a resolution should be introduced asking that the tariff on X-ray eqiupment be definitely abolished.

Intravenous Glucose:

Correspondence concerning prepared intravenous glucose and other solutions and the 40% duty now charged on such importations was read. It was pointed out that such products now manufactured in Canada are not prepared in as satisfactory a form as are certain products available elsewhere. Moreover, certain glucose products manufactured in the United States and available in a more satisfactory form can be retailed in Canada at a lower price, despite a 40% duty. The Executive Committee did not feel that Canadian manufacture should be discontinued, but unless a product satisfactory in form and price were available in Canada, the Customs duty should be abolished. The following resolution was passed:

WHEREAS there are a large number of hospitals in Canada, which do not find it advisable or desirable to prepare their own intravenous glucose solutions and must rely on prepared solutions,

AND WHEREAS satisfactory imported solutions at the present time are subject to 40% customs tariff,

AND WHEREAS such products prepared in Canada are not prepared in as satisfactory a manner and, when prepared ready for use but in inferior containers, actually cost more than certain satisfactory duty-paid products from abroad,

BE IT RESOLVED that the Canadian Hospital Council go on record as favouring the removal of this 40% duty, unless the Canadian manufacturers take steps to meet this demand with more satisfactory prices and products than at present.

Reprints, etcetra:

Customs rulings on several articles were read.

American Hospital Association

The proposed new Constitution for the American Hospital Association was reviewed. It was pointed out that, under this new Constitution, the state and provincial hospital associations would be given an increased share of responsibility, particularly, if the Advisory House of Delegates be set up. Some fear was expressed that the membership of Canadian hospitals might be affected were the membership dues raised very much, particularly, as the Canadian hospitals do not benefit from the legislative activities of the American Hospital Association. Should the House of Delegates be set up, it was the opinion of the Executive Committee that it might be preferable to have Canadian representation through the Canadian Hospital Council rather than directly from the various provincial and other associations.

1937 Meeting

After discussion, it was agreed that the Council should meet this year at Ottawa on Wednesday and Thursday, September the 8th and 9th. This will immediately precede the meeting of the American Hospital Association in Atlantic City.

1939 Meeting

It was announced that tentative plans are being considered by the International Hospital Association and the American Hospital Association for a meeting in Toronto in 1939.

Doctor Claude Munger of New York, and Doctor Harvey Agnew are to officially present an invitation from the American Hospital Association to meet in America at that time. Rev. Father Verreault may attend the meeting in Paris, and he was instructed to present an invitation to

the International Hospital Association on behalf of the Canadian Hospital Council to meet in a Canadian city. He and Doctor Agnew were named delegates from the Canadian Hospital Council to the international meeting. This will be without financial obligation to the Canadian Hospital Council. Doctor Routley, as Secretary of the Ontario Hospital Association, agreed to take this matter up at once with the Ontario Hospital Association Executive respecting a formal invitation to meet in Toronto.

If these arrangements go through, it was agreed that the Council would be well advised to meet in Toronto just prior to this joint meeting.

Maternal Mortality

At its annual meeting in Victoria in June, 1936, the Committee on Maternal Mortality of the Canadian Medical Association requested the co-operation of the Canadian Hospital Council in the setting up of adequate regulations governing maternity practice in hospitals, and also with respect to the compilation of hospital maternal deaths. It was reported that the compilation of recommended regulations for both large and small hospitals is now in the hands of two Canadian Medical Association sub-committees, working in co-operation with the Department of Hospital Service, and that, upon the completion of these reports, such will be referred to the Committee on Medical Relations of the Canadian Hospital Council for its endorsation. Arrangements have been made by the Deputy Minister of Health for Manitoba to study maternal deaths in hospitals and elsewhere in that province; later the study may be extended to other provinces.

Intern Education

The attention of the Executive Committee was drawn to a study of intern education being made by the Committees on Medical Education of the Ontario Medical Association and of the Canadian Medical Association and the Department of Hospital Service of the C.M.A. When completed, this joint report will be referred to the Committee on Medical Relations of the Canadian Hospital Council. If approved by such committee, this report will then be made available to hospitals with the approval of the Medical Relations Committee of the Canadian Hospital Council.

Resolution re Incorporation

Before adjournment a special resolution respecting incorporation was passed:

WHEREAS there is now in existence an incorporated body known as the CANADIAN HOSPITAL COUNCIL,

AND WHEREAS the aims and objects of the said incorporated body are identical with the aims and objects of the unincorporated body known as the CANADIAN HOSPITAL COUNCIL,

AND WHEREAS all the members of the unincorporated Canadian Hospital Council have made application for membership in the incorporated body,

NOW THEREFORE BE IT RESOLVED that the Canadian Hospital Council (unincorporated) be and the same is hereby dissolved, subject to confirmation of the Council in general meeting, and that all records and assets, including money in the bank belonging to Canadian Hospital Council, unincorporated, be transferred and handed over to the CANADIAN HOSPITAL COUNCIL, Incorporated.

Passed by the Executive Committee this 3rd day of March, 1937.

The 1937 Budget and the Tariff Schedule

The recent Budget address of the Hon. Charles Dunning, Minister of Finance, while containing much of interest to cattlemen, textile manufacturers and others, did not contain much of immediate import to the hospital field. The general downward revision of tariffs will be reflected, of course, in some of the hospital purchases, but only a few items directly relating to hospital importations were revised and these do not represent a large turnover.

The 10 per cent tariff on X-ray equipment of non-British origin, perhaps the most contentious point from the viewpoint of hospitals, remains unchanged. Old item 476 which had been affected by the terms of the French and United States pacts has been divided into two portions:

476 (1) Surgical instruments of any material and complete parts thereof—free, free, free.

(11) Dental instruments of any material; surgical needles; X-ray apparatus; microscopes valued at not less than $50 each, retail; complete parts of all the foregoing —free, 10%, 10%.

Spinal braces and parts thereof (236B) are now free under all classifications (formerly 12½%, 25%, 35%).

Certain slight downward revisions were made also in item 220, covering all medicinal, chemical and pharmaceutical preparations, compounds of more than one substance, including patent and proprietary preparations, tinctures, pills, powders, troches, lozengers, liniments, etc.

Surgical dressings, antiseptic or aseptic, including absorbent cotton, etc., are now 10%, 25% and 35%, (formerly 12½%, 25% and 35%).

Note: In the above citations, the first figure refers to the duty under the British Preferential Tariff, the second figure refers to the Intermediate Tariff and the third applies to the General Tariff. Under the trade agreement between Canada and the United States effective Jan. 1, 1936, for a period of three years, Canada extends to the United States the intermediate rates in their entirety and any rates lower than the Intermediate Tariff which may be already extended to other than British countries (i.e., the French Treaty Rate).

A Symposium

I. The Proposed Curriculum of Nurse Education (March issue)

II. Factors Hindering the Efficient Functioning of Training School Studies

By CHRISTINE MURRAY, B.A., Reg. N.,
Instructor, Provincial Royal Jubilee Hospital, Victoria, B.C.

A CURRICULUM is a means to an end, and, in this instance, the end is the education of the nurse. Education means "to exercise the mental faculties of the individual by instruction, training, and discipline, in such a way as to develop and render efficient the natural powers." Nursing is a thinking as well as a doing profession. Are the young women of our schools being trained to think intelligently or are they developing into automatons with doubtful qualities of mind?

The primary responsibility of the hospital is to the *patient*, but the primary responsibility of the school of nursing is to the *pupil*. Too often the aims conflict, the need of the hospital interferes with the education of the student. The patient must be cared for, and the pressure of work is a serious detriment to any formal type of instruction. The reputation of a hospital depends on the service the patients receive; the reputation of a school of nursing is determined by the kind of nurses that it graduates. Can we honestly say that all the nurses from our schools are *good* nurses?

The average person must be taught to think, so, to make our nurses think, our instruction, training and discipline must be effective. There are several factors which help to make a curriculum successful. The two most important are—firstly, we must have good soil in which to sow our seed and, secondly, the seed must be of good quality. In other words, the quality of the material which we take into our schools and the quality of instruction which is given must be good.

I. Quality of Material

Let us first consider the quality of our material. Matriculation is the standard of education required by the majority of our training schools. Does this mean that our students are academically of good quality? Is any enquiry made into the length of time it took to get the matriculation standing or the average marks made during the high school course? A high school student with a grade of from 50 to 60, not over 65 at the highest, will prove the same type of student in a training school. There are still people who say, whether they believe it or not, that a nurse does not need to be intelligent if she has a certain amount of practical skill. There are still high school principals and others who advise students of poor ability to take up nursing, all other fields having been investigated in vain. This is unfair to the nursing profession, for the candidate to be a good nurse must be intelligent, and intelligence is measured in part by ability to accumulate and retain knowledge. The very persons who put forth these ideas are usually the first to condemn lack of intelligence in nurses. Doctors say that we are attempting to give our nurses too much education, but it is those doctors who expect and require the most from the nurse with regard to knowledge of the care of the patient, the reporting of symptoms and the intelligent observations demanded in skilled nursing care.

Why are we forced to keep in our schools nurses who, out of kindness, we class as not bright and who have just made, and no more, the grade of matriculation? They are a drag all the way through and cannot be given any amount of responsibility as senior nurses. When they graduate they find difficulty in finding work. The survey discovered the appalling fact that some nurses are kept, not because of, but in spite of their intelligence. The reasons seem to be that they must be kept to service our wards and care for the patients. Are we being fair to these nurses? They are taken in, guided through a three years' training, guarded and supervised carefully during that time (not given responsibility because not capable of taking it) and then cast out into the world to sink or swim. It is true that all a nurse does is to carry out the doctor's orders, but that must be done intelligently and thoughtfully. Sound judgment is necessary, and sound judgment demands intelligence. If it were not necessary to staff our hospitals with student nurses our processes of selection could be more rigid and the weaker material could be weeded out.

An important part of a nurse's equipment is character and personality. Again, owing to the need for nurses to care for our patients, we must keep students with certain characteristics which are not particularly suited to the nursing profession. Patients do not like them, and doctors will not have them on their cases and it is difficult for them to find occupation after graduation.

II. The Course of Studies

The second consideration is the organization of the course of studies. In the calendars of our schools of nursing there is usually found a course of instruction which is quite imposing with respect to continuity and the number of hours in the classroom. It looks well on paper and the impression obtained is that the school offers a good course of training. The test, however, lies in its practical application. A course of studies, to be successful and to encourage thinking, demands active participation in the classroom. Active participation requires time for preparation. Let us look into the time that a nurse has for study. In the preliminary period the course is most intensive and much time is spent in the classroom. The probationers come into our schools fresh from high school untried, unaccustomed to hard work and responsibility. Adjustments are difficult and take time. A fortnight or so after admission the

senior class members begin to leave as their time is completed, the wards become depleted and the probationers must be used to help fill the gaps left by the promotion of the classes. The probationers' day, like that of all other nurses begins with breakfast at 6.30; they go to the wards from 7 to 9 and so, before they enter the classroom, they have had two hours of active energetic work. They remain in the classroom from 9 a.m. until 4 or 4.30 p.m. It is a long day, practically the whole time is taken up by classes, and there is still studying to be done to prepare for the next day's classes. The subject matter is new, it bristles with technical terms, and a definite effort is required to keep up the work. In order to keep fit a certain amount of rest and recreation must be obtained, so that the time that can actually be spent in study is not very great.

The capped nurses do not fare much better. The day nurses are on duty from 7 a.m. to 7 p.m. with 3 hours off. After six or seven hours of active work, classes must be attended, usually during hours off duty. The nurses are too tired to get the full benefit of the lecture and, far too frequently, they cannot be spared from the floor for classes or hours. Again, they are usually late getting off duty at night and too tired to study effectively. The night nurses are on duty from 7 p.m. to 7 a.m., with two hours off duty. To attend lectures they must get up early, which disturbs their rest. These nurses should have at least eight hours sleep, which means going to bed from 8 a.m. to 4 p.m. or from 9 a.m. to 5 p.m. They must report on duty at 7 o'clock. How much time does this leave for study, recreation and meals? Yet they are expected to attend class, study and be mentally alert at all times. It means simply that our nurses must be keyed up for twelve hours or more most of the days of the week. Is this possible for any individual? Can we ask any of these nurses to participate actively in the classroom activities? The lack of time for preparation means that the lecture method must be adopted.

Another interruption to the course of studies comes with the holidays which must be started during the school term in order not to deplete the wards too greatly.

Still another factor which disturbs the even tenor of the course of studies is the irregularity of the giving of the lectures. As you know, most of the lecturers in our Training Schools are members of the hospital staff and they give gratuitously and most generously of their time to this extra piece of work, but in the very fact that the lectures are an extra piece of work and gratuitous lies the weakness of the system. The lecture hours are snatched either before or after office hours, and as there is no provision made for the exigencies of medical work, the lecture is frequently of necessity cancelled. It is difficult to arrange for an extra, or a lost hour, in a schedule which has been planned to make every moment count.

Clinical Experience

In addition to these factors a very valuable field is being neglected—the field for clinical experience—the ward. A rich field is available, provided the hospital has an adequate number of beds and a good daily average, but it cannot be put to use because—firstly, the supervisors are too busy with administrative duties to spend much time with the pupils, and, secondly, the pupils, owing to the over-crowding and under-staffing of our wards, are too busy attending to the immediate needs of the patients.

After the enumeration of the foregoing conditions I think that you will agree that the *chief stumbling block in the path of a good curriculum is the conflict between the needs of the hospital and the education of the nurse.* Are we giving our students a fair deal? If schools of nursing are professing to train nurses, they must accept the responsibility and offer something worthwhile. The better the course of instruction that is offered, the better will be the type of student that will seek to enter the school. It is a difficult problem and to a great extent it is an economic one. The question of tuition fees, other than the fees to cover uniform and books, should be taken into consideration also. However, this should not be done unless the school has something to offer which will be commensurate with the tuition fee. The proposed curriculum does not seek to increase the number of hours of instruction but to better the kind of instruction, to improve the selection of material so that better nurses will be available to take an active part in the health program of the community.

From Symposium on Proposed Curriculum for Nurse Education, B.C. Hosps. Assoc., Victoria, Nov. 13, 1936.

Income Tax Returns

At this time of the year personal Income Tax returns are in order, and there is always the hope, although not a very bright one, that other sources of exemption may be discovered.

The question has been raised, when can a hospital employee deduct motor car mileage or allow for depreciation when a car is required for hospital purposes? Many administrators and other employees use their cars about the community a good deal in connection with hospital work. Whether or not deduction can be made for motor car expenses would appear to be dependent upon the salary arrangements with the hospital. If there is no mention of car allowance or expenses in the contract, it is doubtful if any exemption would be allowed. On the other hand, some administrators and others have a contract, which provides them with so much salary plus car allowance; this latter is obviously for maintenance and depreciation of a car used in connection with hospital work, and, therefore, would be considered as legitimate expense and not reported as salary. These administrators and others who use their cars a great deal, but whose salary is not divided on this basis, might consider the advisability of such suggestion.

Doctors on salary, such as administrators, pathologists, radiologists, etc., have very limited exemptions. These salaries are taxed without any deduction therefrom, except for annual medical license fees and memberships in professional associations, the total of which must not ex-

ceed $100 per annum. If the professional man on salary must operate a motor car of his own in order to maintain his contractual position and the principal does not pay the upkeep, running expenses, and depreciation, "the individual will be allowed to reduce the salary by such expenses as the use of the car in the earning of his income may cost", either by estimating expenses and depreciation or by charging alternatively 10 cents a mile for mileage covered in the performance of professional duties.

Professional and other individuals on salary are not permitted to deduct purchases of medical or other books, magazines, or instruments.

Hospital employees may not deduct memberships in business or professional organizations corresponding to the organizations for which the memberships are frequently paid by commercial houses; for example, personal membership in a hospital association is not deductible. Expenses in attending hospital conventions are not deductible.

Employees belonging to trade organizations are not permitted to deduct such from their returns.

In those hospitals where a pension fund has been set up with a salary or wage deduction basis of payment, the net income, that is to say, the amount actually received after deducting the pension fund contribution may be reported, if the pension fund has been approved by Income Tax headquarters at Ottawa. If the fund has not been approved, the reportable income should include the drawback for pension fund premiums.

Hospitals have received instruction in all probability with respect to the returnable equivalent for the privileges of living in; for nurses this is considered as $30.00 per month for 11 months.

Members of the medical profession have had an analyses of their exemptions, etc., prepared for them by the Canadian Medical Association. This applies particularly to those doctors who are in private practice and not on salary, and gives the deductions allowed for office expense, instruments, library, motor car and other depreciation and the proportional division of expenses where a doctor practises at his own residence. The doctors in a number of places in Ontario will be entitled to some refund this year, as the Provincial Government has recently returned to the municipalities certain sums of money, which represent duplicate payments made by individuals who paid a municipal business tax in 1936 and a provincial income tax in the same year in respect to their 1935 income. The O.M.A. has sent out word that such individuals may make a claim for rebate of whichever is the smaller sum.

Arrangements Completed for I.H.S. Meeting in Paris

This year the International Hospital Congress will be held in Paris, July 5th to the 11th, and will be under the patronage of His Excellency the President of the French Republic. An interesting program has been provided. The Congress will be preceded by a study journey through the South East of France. For the ladies accompanying the delegates to the Congress a special reception committee has been formed under the chairmanship of the Marchioness de Ganay. The Administrative Headquarters of the I.H.A. will be in the Hotel Ambassador, 16 Boulevard Hausmann.

Special travelling facilities and other courtesies are being arranged by the French government. An added attraction is the World's Fair, which will be in full swing in Paris at the time of the Congress.

Dr. C. W. Munger, President of the American Hospital Association, and Dr. M. T. MacEachern, Chairman of its Committee on International Relations, have made arrangements with the American Express Company for a very interesting European tour. It is hoped that as many as possible of the deelgates going from the United States and Canada will join this party. The arrangements are to leave New York on June 26th, sailing on the MV Britannic of the Cunard White Star Line, England's largest cabin liner. Arriving in Paris on July 5th, there will be ample time for sightseeing.

Following the Congress a most interesting tour has been arranged, going first to Lyons to see the fine hospitals there, then on to Aix-Les-Bains to inspect the famous springs; then on via Geneva and Montreaux to Leysin to see the well known sanatarium conducted by Dr. Rolier in the Swiss Alps. The party will then go on to Interlaken by motor coach, from Interlaken through Furka Pass, the Rhone Glacier and Axenstrasse to Lucerne. Following a free day in Lucerne there is an all-day trip by private automobile via the Black Forest to Baden and Karlsruhe and on to Heidelberg, then to Weisbaden and down the Rhine to Cologne. Then follows a trip to Holland, visiting Amsterdam and the Hague, then by night boat from the Hook of Holland to Harwich; two and a half days in London and return by the S.S. Aquitania, arriving in New York August 3rd. A slightly longer trip taking five more days for England, includes a motor trip through the Shakespeare country. Already three Canadian hospital people have signified their intention to attend the Congress.

Health Insurance in British Columbia Indefinitely Postponed

With the announcement by the British Columbia Government that the proposed compulsory health insurance measure should be postponed sine die, the completion of further details has been help up. Undoubtedly the united opposition of the medical profession to a measure which did not make any provision for the indigent or those unable to pay, and which it appeared would not be able to give adequate remuneration for services to those insured had a great deal to do with the decision to postpone the measure. The collection of levies which was to have commenced on March 1st has been put off. Meanwhile, certain negotiations which had been proceeding have been continued and arrangements, for instance, have been completed with representatives of the British Columbia Hospitals' Association concerning the hospitalization of patients if and when the act goes into force. Naturally, speculation has been rife concerning the political potentialities of the situation and the British Columbia and other papers have devoted considerable space to this aspect of the situation.

Obiter Dicta

Is It Dangerous to Have a Baby in the Hospital?

SOME weeks ago the newspapers of the continent carried a very disturbing statement by a leading Chicago obstetrician. One paper published a headline "Childbirth at Home Safer than Hospital." As a result of this statement, which gave the impression that an expectant mother would be taking greater risks in going to a hospital, reports have been received from many quarters to the effect that the news item had caused great anxiety in the community, had done the hospitals and their conscientious workers a great deal of harm, and had actually resulted in the cancellation of hospital reservations.

The effect of this statement was of sufficient moment that the matter came up for discussion at the recent meeting of the Board of Trustees of the American Hospital Association, and it was there reported that Doctor De Lee had been very seriously misinterpreted. The doctor has stated that the entire review was devoted to urging more maternity hospitals, more teachers and teaching of obstetrics, and more endowments for teaching and research. Doctor De Lee was strongly supporting the well equipped and staffed maternity unit, but was not defending the poorly organized hospital nor the one in which proper segregation and technique in the care of the maternity patient are not followed. What he actually said in connection with the point featured by the press was: "The ideal place for a woman to have her baby is in a special maternity hospital, staffed by obstetrical specialists. The next best place is the well isolated maternity of a good general hospital—staffed by obstetrical specialists; otherwise most women are better off if they have their babies at home." This is a long way from the interpretation placed upon it by the press.

From time to time publicity writers publish "statistics" showing that the morbidity and mortality is higher in hospitals. While many hospitals can successfully refute this comparison with their local community and can show a mortality rate often not more than half that of the maternal mortality for the community as a whole, the statement in some instances is true, but this does not for one moment imply that for any given patient the hospital is a more dangerous place than the home. Such writers seldom mention that the major factor here is that, wherever possible, seriously ill patients or parturient women likely to have complications are sent to the hospital. Most eclamptics and most cases of placenta praevia where an early diagnosis has been possible are sent forthwith to the hospital; most caesarean sections are done in hospital; most cases of contracted pelvis are sent to the hospital as a precautionary measure. Naturally the hospital does have its mortality record raised, because of caring for such patients, but anyone familiar with the problem of maintaining good obstetrical technique in a home with limited facilities and untrained assistants can full well realize what lessened chances such patients would have did they not have a hospital to attend.

Moreover, altogether aside from the factor of increased safety vouchsafed to hospital patients is the added factor of comfort. In a hospital modern methods of minimizing the pain of the first and second stages of labour can be applied much more readily than when the patient is confined at home, where the doctor's attendance can be but intermittent until the final stage, and where the attendants can seldom be entrusted to give the type of relief from pain which can be safely ordered in a hospital.

At the same time hospital workers must never forget that there is always the danger that a clean obstetrical patient may be infected from one of the many pus cases cared for elsewhere in the hospital. Only the most rigid technique and surveillance of medical and nursing care can prevent an occasional cross infection arising. All too many of our hospitals, particularly smaller ones, do not properly segregate their obstetrical patients, not only by their allocation in the hospital but by the nursing routine. With limited staffs, nurses, particularly at night, must care for both obstetrical patients and pus surgery. Caesarean sections must sometimes be delivered in the one operating room and such operation may immediately follow a pus appendix or similar septic case. Naturally, such procedures endanger the lives of the obstetrical patients.

In a larger hospital or in a community capable of providing proper maternity service such inadequate facilities should be roundly condemned and proper measures taken without delay. On the other hand, one cannot be too condemnatory of smaller hospitals. Many of these smaller institutions have been built and are being maintained with great difficulty; no one knows more than those in charge the handicaps due to such limited services, and those in charge would be the first to demand better facilities were the erection and maintenance of such economically possible. Many such communities are glad to have any place where the obstetrical patient can receive adequate medical and nursing care, and it is to the credit of the workers in these institutions that, despite all these difficulties, they are giving the community better obstetrical care than would be possible without such hospital facilities.

What Constitutes An Indigent Patient?

By S. H. EDWARDS,
Secretary-Treasurer, Bassano Municipal Hospital, Bassano, Alberta.

AFTER reading Dr. Gray's article "What Constitutes An Indigent Patient" in the February issue of "Canadian Hospital", one is forcefully reminded of the fact that each Province of the Dominion is charged with the responsibility of formulating legislation governing its own domestic affairs, with the result that the consequent legislation of one province is very often different to that of each of its sister provinces, although the problems of each are identical. Perhaps that is as it should be; environment and local characteristics being what they are. One would naturally think, however, that in a large number of instances, the legislation of each of the nine provinces on fundamentally the same questions could coincide and co-operate with each other without working a hardship on any citizen or being the foundation for an injustice.

The case in point is contained in the last paragraph of Dr. Gray's article wherein he hints that any statutory definition of the word "indigent" would prove to be not satisfactory in all cases and that the facts of each individual case would ultimately have to be the deciding feature. Granted that the facts of any case decide the issue, where no definition of the term "indigent" has been established by authority and the dictionary or popular meaning has to be relied upon, confusion is sure to arise. There are plenty of dictionaries, and the meaning of the people changes. It would appear far more economical and satisfactory to everyone concerned if legislation were put on the statute books of each province clearly defining all the important terms used in the statutes, rather than leave them indefinite and fit subjects for Court interpretation. The definition of the term "indigent" in a few simple words should not be beyond the capabilities of the Government of the Province of Ontario. Alberta has accomplished the task in a short, lucid sentence which has remained unchanged for at least fifteen years. Chapter 60 of The Revised Statutes of Alberta 1922 is entitled "The Hospitals Act" and sec. 6, subsec. (3) (a) of that Act reads as follows:

> "'Indigent person' shall mean a person who is actually destitute of means from his own resources of obtaining the food, clothing, shelter and medical attendance necessary for his immediate wants."

This interpretation is, of course, applicable to "The Hospitals Act" only, so far as is known, and it thus has to do with "what constitutes an indigent patient" which is the subject of our present study. There does not appear to be anything debatable about this interpretation, and it is the general understanding that in Alberta, Court actions to decide whether or not a patient is indigent are very rare. Seeing that the definition deals with a "person" and that all hospital patients are persons it would seem that the age or dependency of a patient is immaterial in deciding the question of the person's indigency. It is, of course, generally considered that a minor child is the responsibility of its parents or guardian and the status of a patient who is a minor and dependent is considered to be the same as that of the parents or guardian. In the event of repudiation of responsibility by the parents or guardian, however, there appears to be nothing to prevent the minor being treated as an indigent person in his own right, as it were, because of the words "from his own resources." Our patient, unless he has, at the time of admission to hospital upon a doctor's request, sufficient means to provide himself with food, clothing, shelter and medical attendance he is indigent under the law. It would probably be a great surprise to many people to learn that they were indigent according to the letter of the law. There are literally hundreds of heads of families in this province who, by the practice of thrift and economy, are managing to keep the home together who are absolutely unable to pay any part of the cost of hospitalization or an emergency operation. All these folks are indigent because our statutory definition of the word adds medical attendance to the bare necessities of life in its recital of the four requisites. If he has to deny himself any one of the four to provide the other he is properly classed as indigent.

It is problematical if the last word of the definition would be taken, in a Court of law, to mean what it says, for a person's "wants" are, very often, entirely different to his "needs", and it would seem as though the word "needs" would be more appropriate here. There is the general conception of what constitutes an indigent patient in the Province of Alberta. A Judge of the Court might take a different view and find all kinds of disputable points, but to the layman engaged in hospital work there does not appear to be any difficulties.

There are two classes of indigent persons with whom a hospital has to deal: those having no permanent home or who have not established residence in the Province are classed as "indigent transients" and, otherwise, "indigent residents." "The Hospitals Act, 1922" of Alberta defines a resident as any person who has had his home, or who has been a sojourner within an area controlled by a local authority for at least three successive months of the six months immediately preceding the date of application for placing such person in a hospital. Sick indigent residents are the responsibility of the local authority controlling the area of which they are resident and the hospital can collect from such local authority; but in the case of indigent transients the Provincial Government rules that the hospital shall receive nothing more than the per diem grant of forty-five cents per patient day. On this latter point it is evident that the hospitals are the victims of a grave injustice.

The per diem grant provides for only a very small portion of the cost of hospitalization, and two or three indigent transients in the course of a year's operation can easily put the balance for the year on the wrong side of the ledger. It is thought that an indigent transient is properly the responsibility of the Province as a whole, or of Dominion. At any rate they should not be considered as the responsibility of the hospitals which now have to bear it. The whole question of indigency is a large one and one, that to all appearances, is still worthy of intense study by all the legislature bodies of the Dominion.

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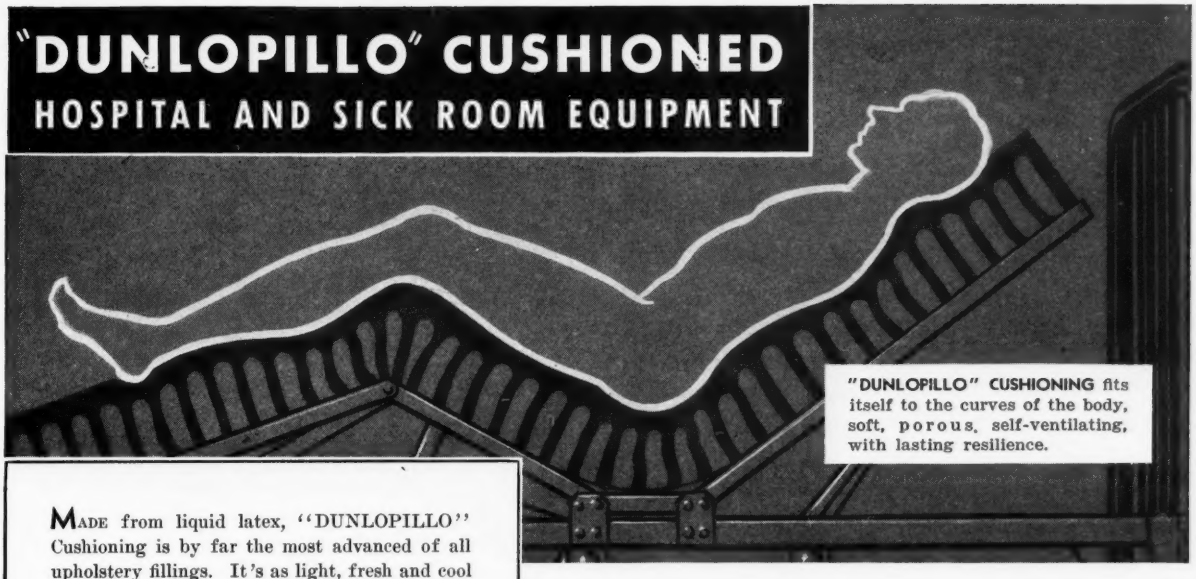

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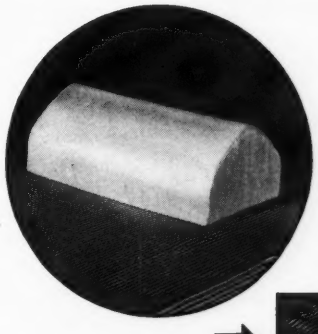

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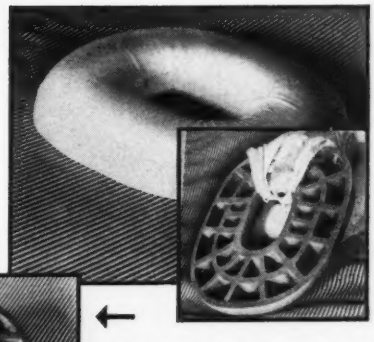

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"Uniform"

THE other day a young waitress from the dining room had occasion to pass along a ward corridor. A visitor accosted her with "Nurse, can you tell me", etc. Explanations were forthcoming and the visitor was put in contact with a nurse.

To the staff of the hospital there was no similarity between the graduate nurses' uniforms and that of the waitress, but to the visitor the white uniform and cap spelt "nurse," Following this incident a check was made throughout the hospital in an endeavour to find if any other members of the female staff had been mistaken for nurses on more than one occasion. The result of the inquiry showed that the following members had—Dietitian and her assistant, technicians in several departments, secretaries and stenographers, telephone operators, as well as kitchen and dining room maids. The only thing the staff from these miscellaneous departments had in common with the nurse was the fact that they wore white.

Graduates' Uniforms Vary

On going further into the matter it was found that the graduate nurses were none too pleased about the close similarity of dress and felt that these other staff members were encroaching upon their ground. More investigation took place and it was found that on that particular day, of twenty-one graduates who were wearing other than their school uniform, there were no two dressed alike beyond the fact that they were in white, but on checking the other departments it was found that all secretaries, stenographers, and telephone operators were dressed alike in every detail. The same applied to the waitresses, and upon consulting catalogues it was found that these other departments had had their uniforms chosen for them from appropriate sections of the catalogues, and further that when once decided upon, the form of dress was set by hospital regulations. The graduate nurses, however, had not confined their choice of dress from catalogues of nurses "uniforms", but had invaded the complete field of white dresses. In other words we have to admit that graduates dressed in white were on duty without being uniform, for the word "uniform" as defined by the dictionary does not allow for even the slightest difference of design other than distinguishing marks of rank.

Is Such Variety Desirable?

These facts seem to show the erring party to be that of the graduate nurse. Surely as the senior group of a senior service they are not going to let the dictates of fashion deprive them of the right of applying the term "uniforms" to their style of dress, for with the term "uniform" we think of such terms as "authority", "professional dignity" and "discipline". Furthermore, they can hardly expect other hospital personnel to refrain from getting a form of dress resembling that worn by the graduate nurse if the nurse invades the whole field of white dresses. It may be suggested that other staff wear coloured uniforms, but this would appear too monopolistic and after all white, cleanliness and hospitals seem to blend ideally together.

What have the graduate nurses who wear white dresses to say about the matter? Is it worth discussing?

A Reorganization in the Dietetic Department of the Vancouver General Hospital

Department of Dietetics — Director, Ethel C. Pipes
Teaching Section — Frances D. Wyness

IN September, 1936, a start was made toward the closing of the diet kitchen and serving of therapeutic diets as a variation of the general diet. (Much the same type of project has been worked out advantageously in several of the larger hospitals in the United States.) Four wards were chosen as a first step: of these two are medical, one is surgical and one is pediatric.

The change has been brought about through the normal outgrowth of three trends in hospital dietetics in the last decade:

1. The first was the change in the conception of the therapeutic diet. Formerly only the pathologic process was provided for, while now the nutritional requirements of the patients are no longer secondary to his therapeutic needs.

2. The second trend was making therapeutic diets vary as little as possible from the regular hospital of home menu. The hospital diet can generally be used as a basis for therapeutic diets, without disregarding modifications and necessary restrictions. Where this system is used, it seems better for the patients, both physiologically and psychologically; it is an economy and a convenience.

3. The third trend has been the better control and management of food production, which has made it possible to depend upon the main kitchen for the preparation of therapeutic diet foods.

The Mechanism of the New Set-up

Foods are prepared in the main kitchen and sent to the wards (except a few diet extras and diabetic foods prepared by the students). The dietitian in charge of the kitchen makes out the menus and a daily list of extras from which the student orders. The student dietitians and student nurses assigned to the wards are responsible, under supervision of staff dietitians, for the nutrition of the patients in their divisions. Their responsibilities begin in the teaching office of the department, where the diets are worked out and a list of diet extras (orders) made; each then prepares the diet extras in the diet kitchen, and goes to the ward to check out the trays that are served by a ward maid. The nursing department is responsible for the delivery of the trays to the patients, and the return to the diet pantry. The plate waste is checked by the student. The student dietitians order the supplies for the pantries. Patients are visited at least twice a week; many are visited more frequently.

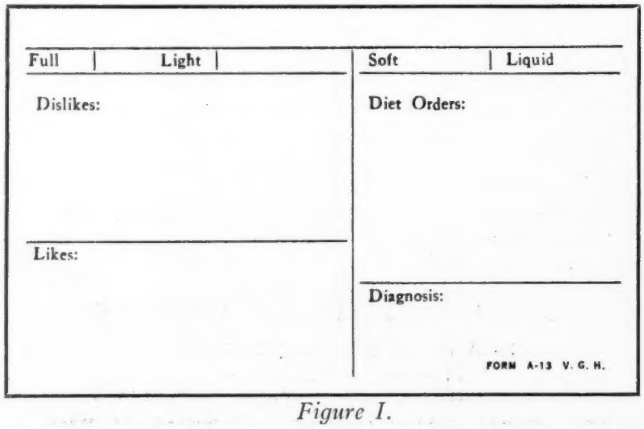


Figure I.

The student keeps a diet record on the chart, and teaches patients the principles of normal nutrition, in the same manner that health habits are taught. Every day the students have a conference with the supervising dietitian, who checks the charts and the service of food.

The Forms Used on the Service

1. Tray cards of white (for full diets), blue (light), green (soft), orange (fluid), yellow (for special), and red (for diabetics), carry the patients likes and dislikes, and fit into small wooden blocks on the trays. These are removed when the tray leaves the kitchen.

2. The office record cards kept in the Dietary teaching office are illustrated by Figures I. and II.

These cards (Figure I.) are printed on both sides as an economy measure. They are white for general diets, yellow for therapeutic diets, and red for diabetics; and are kept in recipe boxes. Small paper clips are used to designate whether diet is full, light, soft or fluid. (This also is an economy measure in place of an expensive file cabinet with celluloid slide indicators.)

3. Diet Record Chart Sheet (Green). Figure II. The student dietitian and student nurse from the dietetic department, chart on this sheet. The ward nurses also chart anything relevant to diet on the Diet Record sheet.

The Advantages of such a System

The establishment of this change is of definite value to patients, student nurses and student dietitians; and of assistance to the graduate staff.

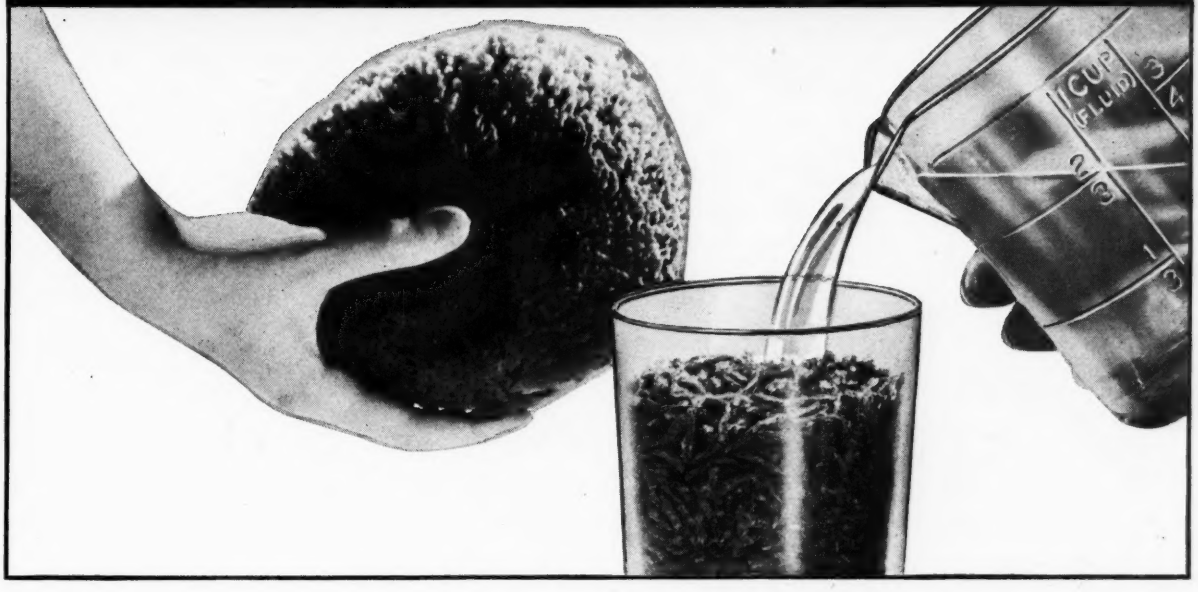
1. Contact of dietitian with the patient and the doctor.

(Continued on page 28)

Department of
The Canadian Dietetic Association

Conducted by
Ruth Davidson Reid, B.A.
James A. Ogilvy's Limited, Montreal

TRY THIS EASY TEST YOURSELF



See ALL-BRAN absorb water like a sponge

HERE's a test you can make in a few minutes. It will convince you that Kellogg's ALL-BRAN acts, in the intestinal tract, much like a water-softened sponge.

Fill an ordinary glass four-fifths full of Kellogg's ALL-BRAN. Pour water up to the brim of the glass. Soak about fifteen minutes, and drain off the excess water. Feel the water-softened mass. It's as soft as a wet sponge.

Laboratory tests show that Kellogg's ALL-BRAN absorbs at least twice its weight in water. Within the body, this softened "bulk" gently exercises and cleanses the system.

In addition to generous "bulk," ALL-BRAN supplies vitamin B, needed for intestinal activity. ALL-BRAN also furnishes iron for the blood. This natural food is more satisfactory than the continued use of pills and drugs.

ALL-BRAN may be enjoyed as a cereal or cooked into recipes. Sold by all grocers. Made and *guaranteed* by Kellogg in London, Ontario.

Serve *Kellogg's* ALL-BRAN regularly for regularity

2. The dietitian is able to consider the dietary problem of all patients in the ward; formerly she was interested in only those on therapeutic diet.

3. While the co-operation and the interest of the head nurse are vital to success, it relieves her of the serving of trays and ordering of food.

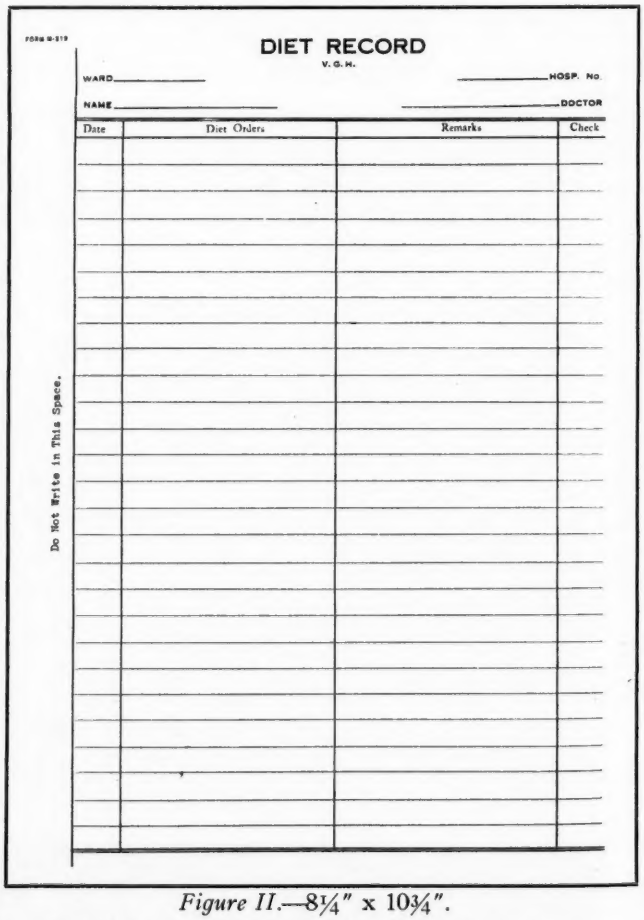
4. It places the responsibility of food temperature, adequacy and attractiveness squarely on the shoulders of the dietitian, who is trained in this field and is primarily interested in it.

5. Qualified cooks prepare the food for all patients, in place of student nurses, to the betterment of the quality of the food.

6. It co-ordinates medical care and diet therapy in the minds of students, vitalizing our teaching. It gives the student dietitian an understanding of the proper relationship between the dietetic department and other departments of the hospital.

7. Since food is prepared and distributed from one kitchen, food waste is reduced in that it avoids duplication.

The department has taken a step forward, and though there may be limitations due to the architectural plan of the institution and to the lack of equipment, we are firmly convinced that it would be advantageous to bring all the wards under this type of food service, not only from the educational but also from the administrative point of view.



DIET RECORD
V. G. H.

WARD _____ HOSP. NO. _____

NAME _____ DOCTOR _____

Date	Diet Orders	Remarks	Check

Do Not Write in This Space.

Figure II.—8¼" x 10¾".

In addition, for diabetic patients, a special sheet is used, combining diet ordered, amounts consumed, insulin given, urine analysis and blood sugars.

The Hospital and the Doctor

THE hospital and its organizations is one of the principal mediums through which the physician and surgeon administers to his patient. It can perhaps be termed the centralization point of his bedside practice, therefore if such institution can give his patient through him an efficient service it will end in the common good to patient, physician and hospital—therefore a hundred per cent co-operation policy is necessary.

A doctor can unconsciously defeat the end (efficiency) by causing a drain upon the hospital's budget through unnecessary expenditures upon the individual patient either through prolonged, unneeded hospitalization of the non-paying individual or costly experimentation, particularly with expensive drugs. Such practice eats into the expenditure side of the budget so that expansion in productive service is greatly minimized or perhaps found impossible and so both doctor and hospital suffer, which means the patient and the community suffers.

If a clear thinking medical staff proposes a policy to the Board of Governors for improvement in medical service, such proposals must receive every consideration in the budget or the revenue side will suffer through decreased hospital days due to lack of service.

The relationship between Board and Medical Staff will find its smoothest channel through the Superintendent who by virtue of knowing two points of view becomes the ideal mediator of both, the connecting links between the three should be very close and very strong. This is most efficiently brought about by frequent conferences and broadminded friendship not with the individual but with the body as a whole or a committee of the body.

When a medical man is accepted upon the staff of a hospital it is the duty of the hospital to see that he receives every service possible to efficiently and ethically carry on his work. The organization should be such that he can devote his whole mind to the patient, but it is the duty of the medical man before accepting such appointment to make himself conversant with the regulations of the institution and the medical staff, and upon acceptance to carry out such regulations to the utmost detail, for they have been created from experience to give the greatest efficiency to the whole, even if they fail, in instances, to the individual. Broadminded understanding of regulations are the keynote to co-operation and offending regulations should be removed promptly, providing the removal will be to the mutual advantage of all concerned.

Medical men, by virtue of their profession, have a deep understanding of humanity, and their knowledge is of high value in many matters of a non-medical nature met in hospital administration. This knowledge cannot be utilized too often. On the other hand the Board of Governors and its administrative personnel by reason of its business experience can very often be of service to the medical man as to the economic structure of the patients' budget. By that it is meant that quite often if the medical man left the choice of rooms and service, etc., for the patient and hospital to decide and gradually wean the patient from the idea that a physician is the best judge of their financial position, it would eventually work out to a greater advantage to all concerned.

Ontario Hospital Association News

WE have had many bitter complaints from hospitals throughout the province with regard to the confusion and difficulty caused through the new forms in connection with public ward pay patients. Many hospitals claim that it is very difficult, if not impossible, to get the required information from the patients.

The Department of Hospitals also points out to us that in going through these forms, they find that many patients are paying $1.75 per day whose incomes are very small indeed, while others, with much larger incomes are paying the same. The Department feels that where patients are only in hospital for a day or two, as in the case of a tonsil operation, if the patient can pay $1.75 he can pay $2.35, and it would avoid a tremendous amount of work both for the hospitals and the Department, if the hospitals tried their best to collect $2.35 per day in such cases.

May we also ask that the hospitals be as patient as possible and do the best they can with these forms for a reasonable period, in the hope that it may be possible in the near future to work out some plan which will do away with them.

* * *

Please mark up the Convention place and dates: Toronto, October 20, 21, 22.

* * *

As a result of a proposal by the Workmen's Compensation Board to set up a new scale of fees for X-ray work done for their cases, representatives of the Ontario Medical Association and the Ontario Hospital Association met the members of the Board on March 23rd.

A Brief had been carefully prepared by the two associations. The Board met us very cordially and there was a very full discussion of every angle of the whole matter. Although we are not able to state that a complete agreement has been made as to these rates before this must go to press, we feel that whatever rates are finally adopted by the Board will be done in full co-operation with the Associations concerned.

As soon as the matter has been settled, we shall advise the hospitals of Ontario by circular letter.

We understand that hospitals are being asked to enter into special agreements with some large organizations to accept patients at special rates. Might we suggest that in the interests of your hospital no such agreement be signed until it has been submitted to the Board of the Association for their advice.

The Association has launched upon the publication of articles in the press of Ontario to inform the public as to what the hospitals are really doing for the people and how well and economically it is being done.

The first of these articles has been apparently very well received both by the press and the public, if the numerous clippings which have come to our hand are any indication. Another article will appear in a few days.

Women's Hospital Aid News

— 1865 — — 1937 —

"If you have knowledge, let others light their candles from it, that the light of understanding may spread abroad."

The creation of the universe is described in (Genesis) in about six hundred words.

The Lord's Prayer contains sixty-eight words, and has all the essential facts. Words are good tools when not over used—every time a person open his mouth, he creates an impression favourable or otherwise, we are attracted or repelled.

As a consequence in our work relating to Public Relations—we would do well to ponder the foregoing. Speak simply, winsomely, briefly and intelligently.

Voluntary Aids are advancing favourable hospital mindedness through National Hospital Day committees in the following avenues; radio talks, on the screen, cleverly arranged merchants' window displays, school children make posters, school children write essays, display posters in all public places, place stickers on out-going mail, churches, schools, clubs, etc., co-operate in brief addresses relating to the significance of National Hospital Day, get co-operation of the press, send out invitations to clubs, etc., to visit hospital on that day, ask dairies to carry advertisements on milk bottle stoppers, have special cards for all hospital trays, dedicate rooms and new units to this day, assist in receptions and inspections in hospital (in co-operation with superintendent and board), serve special afternoon tea at hospital, contribute to making mealtime in the hospital specially attractive on this day; send out National Hospital Day invitation cards—"Will you please visit the Hospital on May the 12th, National Hospital Day", members of the Aid will assist in welcoming you; baby birthday parties are held—all babies born in the hospital during the year; young matrons in colored smocks (glorified messengers) assist in social service department and act as hostesses to mothers serving tea and biscuits. The convener of this committee should be conversant with the needs so that these voluntary helpers may not be a hindrance in any way. They also act as library committees, distributing books in public wards. Many very kindly also have their motor cars available to take mother and babe to and from hospital during a birthday party.

Hence National Hospital Day celebrations through the foregoing channels assist in building bridges across the streams of indifference, misunderstanding and misinterpretation between the hospital and the citizen. It is a golden opportunity for hospital personnel, voluntary workers and the citizen to clasp hands in cordial greeting, making obeisance to a great humanitarian service; a golden opportunity to show appreciation of your hospital and all it stands for.

A good hospital aid member should be as alert, as prompt, as dependable and available as we expect the hospital service and personnel to be at all times. The citizen who advances any good causes for humanity wins happiness, not only for others but for himself. Voluntary hos-

pital work is descended from the past, we are the guardians of the future, our work and achievements are the children of to-morrow; we must nurture them, guide them for future days. Ideals, pure motives, courage, perseverance, vision, skill and kindliness roll many an obstacle away.

Book Review

"An Introduction to Medical Science." By William Boyd, M.D., M.R.C.P. (Edin.), F.R.C.P. (Lon.), Dipl. Psych., F.R.S. (Can.) Professor of Pathology in the University of Manitoba, Pathologist to the Winnipeg General Hospital, Winnipeg, Canada.

This book is written in a clear and concise style without too many technical terms. The subject matter has been arranged in such a manner that it is valuable to the individual who has the need of a clear perception, without detailed information, of disease, cause and treatment, as well as prevention. The ilustrations, of which there are over one hundred, give the reader a clearer understanding of the content.

"An Introduction to Medical Science" should prove an excellent text for Schools of Nursing which include an elementary course in Pathology and Bacteriology on their Curriculum. The nurse will find the final chapter invaluable in that laboratory reports are explained so that they can be read intelligently and with meaning, without emphasizing the laboratory technique.

Teachers and members of the laity who are interested in this subject will find Doctor Boyd's book a valuable source of information.

Dr. R. J. Collins to Attend Meetings in London

Dr. R. J. Collins, Superintendent of the Saint John Tuberculosis Hospital, has been granted two months leave of absence to attend the Conference on the After Care of Tuberculosis to be held in London, England, from May the 3rd to the 13th. This conference has been arranged by the Overseas League, and is under the auspices of Sir Varrier Jones, head of the Papworth Colony for the after care of tuberculosis. Dr. Collins leaves on April the 15th.

WE WOULD LIKE TO KNOW—

The Editorial Board will be pleased to answer in this column any question they can that will be of general interest to hospital workers. Kindly mail questions directly to the Editor.

Q. Would you kindly let us know what the usual charge is for the administration of oxygen therapy, or if the charge is for the oxygen only?

A. When oxygen is administered without the use of highly specialized equipment it is usually charged for by the pound as this seems to be the most convenient form of meterage. In calculating the cost per pound the transportation cost of tanks both to and from the source of distribution must be included and because of this the charges by different hospitals vary considerably due to the difference in distance from the source of supply. When the more specialized oxygen therapy apparatus is used such as tents or rooms it is usual to make a charge that will accumulate a sufficient reserve to replace the apparatus when worn out. It is perfectly in order to make a reasonable service charge for any type of oxygen therapy particularly when it is considered that some of the accounts will not be paid. For example, the service charge for an oxygen tent may be anything from $4 to $10 per day depending upon the situation of the individual hospital.

Q. What methods can be used to create interest among the various department heads relative to the hospital as a whole?

A. The staff conference is without doubt the best means of creating an esprit de corps between department heads. Properly conducted such a conference will break down any or all problems that may arise through lack of understanding between the departments. The administrator should attend such conferences but it has been found to be good practice in many hospitals for him to act only as a consultant during the conference. A very good idea is to have a different department head act as chairman each month and while occupying this position be expected to lead a brief discussion on his or her particular departmental problems, also including the conducting of a tour through the department during which a fair amount of details of operation should be covered. Following such a tour it will be found that many supposed problems of other department heads will disappear without further discussion and a tolerance for the department in question will be created. The round table discussion should be concluded with a summarization by the administrator. Occasionally when it is found necessary to work up a special interest the luncheon-conference can profitably be resorted to, problems always seeming less troublesome after pleasant social intercourse. Members of the governing body can be invited to certain of such conferences and thus learn of departmental problems to the advantage of all concerned. It may be good policy for the administrator to find it impossible to attend occasional conferences for by so doing the odd problem may be threshed out freely that might be curtailed by his presence. A staff conference should be held at least once a month.

Q. What is the most efficient system for getting repair work done?

A. Requisition forms should be provided to each department head. When repair work is necessary this requisition should be filled in concisely by the department head explaining what is needed and why it is needed. This requisition is then submitted to the administrator or his deputy and a decision made as to the necessity or desirability of the work being done. If it is decided that the work is to be done then the requisition should be addressed to the department concerned. This is best done in the administrator's office as very often department heads have a tendency to draw the requisition on the wrong department, thus causing unnecessary handling of the requisition. The department to whom this requisition is addressed immediately upon receipt stamps the receiving time thereon. Provision should be made upon the requisition to show the time that repair work is actually started and concluded, as well as a place for the signature of the repairman. When the work is done the department head under which the repairman works should inspect the work and initial the requisition as so inspected and at the same time obtain the signature of the person requesting the work, stating that it has been done to their satisfaction. The requisition is then filed in the department doing the work. Such requisition should be made out in duplicate, the copy, of

course, being kept by the department making the requisition. It is good policy to cancel this duplicate when the work is done.

Q. We have a medical anaesthetist on our staff full time but the work in this department actually occupies little more than half of his time, how best can the balance of his services be utilized?

A. Providing the anaesthetist is agreeable and you have interns on your staff, it would seem a very profitable move for all concerned that he devote himself to sponsoring intern instruction and problems that would ordinarily have to wait for meetings of the intern committee. Most intern committees would appreciate such a move for they realize that in between meetings many minor problems arise which could most efficiently be dealt with at the time. Such duties would not interfere in any way with the authority of the intern committee or the residents as the anaesthetist would act more as a consultant or father confessor to the interns. Another duty in which his medical training would be of value to the hospital would be in the supervision of the record room. Record librarians have many medical problems while endeavouring to complete their charts and statistics and they would appreciate the assistance that could be given by this medically trained person.

Dr. J. C. Paterson New Pathologist at Regina General Hospital

Dr. J. C. Paterson, of the Banting Institute, Toronto, has been appointed pathologist to the Regina General Hospital. In the interval since Dr. R. C. Riley's resignation Dr. Eric Massig, of the Provincial Department of Health, has been carrying on the work of the laboratory.

Balancing the Hospital Budget

BEFORE a budget can be balanced successfully it is necessary that every governor or trustee be familiar with the function of each department of the hospital—should understand the service required of the department, the cost of such service and the returns that should be reasonably expected from such service. This requires time and sacrifice on the part of the individual, but the duty of governorship should not be undertaken unless such time and sacrifice is forthcoming.

To secure constant revenue the goodwill of the community is vital. This can only be obtained by a high type of service which can be brought about by staff co-operation; therefore the staff must be considered and understood, to maintain efficiency. Does your staff get fair consideration? Or is your budget suffering?

Expenditures can be controlled by efficient departmentalization. Each department must be balanced as to function. One outstanding department may show a normal functioning department in a poor light. A surgeon cannot operate unless your engineer produces steam for sterilization; therefore co-operation is essential. To keep an economical balance between departments, have frequent staff conferences to discuss common problems and create friendship.

The hospital superintendent is the prime mover in balancing the budget, but he cannot act without the full support of the Board; therefore the superintendent and the duties of the office must be known in detail to the Board. He is paid to administer, but can do it with a great deal more confidence if the feeling that the Board are nearby and understand is in existence. The lack of such understanding is a big mark on the debit side of the budget always, but because of its indefinite nature it is hard to trace.

A budget cannot be balanced unless the controlling body of the community understands the problems of the Hospital Board. The Board must do their share in advising such bodies so that the people of the community are intelligently informed on how and why their money is being spent.

A well balanced budget is one that gives the people the greatest service for every dollar spent and earned. The solution is not found in figures only—it is brought about by profound understanding between every person connected with the hospital, from the President of the Board to the garbage man. If your budget does not show to its best advantage, why not investigate from the angles suggested above, before perhaps making drastic cuts in service which may throw the balance out even further.

National Hospital Day

As National Hospital Day this year falls on the same day as the Coronation Ceremonies, it would seem in the interest of all that National Hospital Day be postponed. A tentative date suggested is one week later, namely, May 19th. With this thought in mind your Canadian representative to the National Hospital Day Committee has written to the Chairman suggesting this alteration in date. As an answer can not be received in time for publication in "The Canadian Hospital" we urge hospital administrators to keep the possibility of this change of date in mind.

The Superintendent

"The duties of every superintendent are so manifold and complex that if he is to succeed he must be ready to meet every emergency with stern decision or tender understanding. He must not stand upon the border but must be ready with initiative to act in any crisis; he must have strict rules of administration, but must not hesitate to break them if it be for the common good. He must be a disciplinarian but not a tyrant; an impartial judge, yet a father confessor of his employees. He must be a shrewd business man, but capable of forgetting economies which stand in the path of the patient's welfare. He should be a man stern, tender, forbidding, forgiving, impartial, considerate and above all, humane.

"The ideal executive is a person who, in the first place, knows his problems, who sets high standards and insists on their observance, who deals promptly with departures from such standards but who is known always to be just and impartial in his decisions. He must have almost absolute authority but he should appear never to exercise it.

"He must be the buffer between the Board and the Medical Staff; he should be the adjuster of the problems which arise inside the institution and is responsible to the patient and the public.

"Hospital administration is both an art and science and requires for its successful conduct catholicity of experience and knowledge, clever ingenuity, broad vision, adaptability to environment, dauntless courage, keen perception, inspiring leadership and relentless industry. A hospital is at once a hotel, an industrial plant and a college. Its clientele are persons who for the time being are abnormal in body and mind. It has a wide scope of contact with the public and its personnel includes individuals who vary from char-women to cultured professional women and from laborers to highly specialized scientists. No wonder then, that hospital administration is a most exacting calling, demanding that those who follow it hold fast to the profession of their faith without wavering."

Extract, Bulletin No. 72, A.H.A.

Penetang Superintendent Resigns

Miss Hilda McDonald, superintendent of the General Hospital, tendered her resignation to the Board to take effect March 15th.

The Coronation

It is expected that a number of hospital administrators and medical men will visit England for the Coronation, and whilst there will naturally wish to take the opportunity to familiarize themselves with recent developments in all branches of their calling.

British manufacturers of medical equipment will most cordially welcome any opportunity they may be afforded to acquaint visitors with their latest productions.

Messrs. Watson & Sons (Electro-Medical) Ltd., manufacturers of X-ray and Electro-medical apparatus, desire us to make known the fact that they will be very pleased to escort visitors over their new factory at Wembley, Middlesex.

Those desirous of availing themselves of this invitation are asked to get into touch with Watsons at their London office—Parker Street, Kingsway—when they will arrange for an escort to accompany them to Wembley.

Here and There in the Hospital Field

By HARVEY AGNEW, M.D.,
Secretary, Canadian Hospital Council

BRANTFORD, ONT. — At a meeting of the Ontario Mayors' Association on May 5th two resolutions of interest to hospitals were passed. One requested the provincial government "to lay down definite regulations by which municipal councils may control payments to hospitals and obtain a greater co-operation from the medical profession." The second resolution requested the government to take over the entire cost of hospitalization as "the burden to property owners has become unbearable."

* * *

CANADA.—"Coronation" dances are being arranged in various cities of Canada in aid of the campaign against cancer. These are being sponsored by the Canadian division of the United Commercial Travellers to commemorate the coronation of King George VI. These functions will be held on April 12th as many prominent citizens plan to be in England in May. Plans have been completed for a banquet in Vancouver under the patronage of the Lieutenant-Governor, the proceeds to go to the British Columbia Cancer Foundation.

* * *

CHICAGO.—Of value for reference is an authoritative volume on "Incorporation, Taxation and Licensure of Hospitals in the United States," just issued by the American Hospital Association. This is one of the many excellent studies undertaken by the Council (formerly Council on Community Relations and Administrative Practice) of that body, and was prepared by a subcommittee under the chairmanship of Dr. Joseph C. Doane, of Philadelphia.

* * *

CHICAGO.—We don't know how to pay salaries in Canada. It was recently announced in the Chicago press with action photographs 'n' everythin' that the Cook County Hospital had finally succeeded in taking over from the county jail an expert in cooking, who, for $25,000 a year, will try to make the hospital as popular as the jail. As the Sheriff said, "He didn't want the job and he is doing the county a favor."

* * *

EDMONTON, ALTA.—A number of changes have recently taken place in the Edmonton General Hospital. Sister Clarinda Fortin succeeds Sister Mary D'Echaristie as Superior, Sister D'Echaristie being transferred to Manitoba. Mr. J. A. Galland of St. Paul, a well-known Alberta merchant, has been appointed as hospital purchasing agent. Mr. J. A. La Chasseur who has been attached to the General Hospital staff for a number of years as collector has been appointed business manager.

* * *

KAMLOOPS, B.C.—At the annual meeting of subscribers ot the Royal Inland Hospital the Chairman of the Governors, Mr. A. E. Shaw, reported on the great improvement in the finances of the hospital. A surplus of $7,633 was reported in contrast to liabilities of some $30,000 in 1933. Mr. Shaw pointed out that a portion of credit for improved conditions at the hospital must be placed with the voluntary insurance scheme adopted in April, 1934. An all-time high enrollment was reported at the close of 1936, some 1900 heads of families or single subscribers being on the roll giving a net gain of 209 for the year. A number of improvements to the hospital were reported.

* * *

LONDON, ENGLAND.—St. Bartholomew's Hospital have an X-ray tube weighing some ten tons, which is the largest in the world, and is capable of producing rays equivalent to those produced by $40,000,000 worth of radium. The tube is some thirty feet in length and to protect the workers it has been necessary to build special buildings with barium-concrete walls.

* * *

MONTREAL, P.Q.—Dr. F. E. McKenty, M.D., C.M., F. R.C.S., F.A.S.C., was appointed surgeon-in-chief of the Royal Victoria Hospital. Dr. McKenty succeeds the late Dr. F. C. Scrimger, V.C.

* * * *

MOOSE JAW.—The honour of having the first sit-down strike goes to the Moose Jaw General Hospital. This was staged by all of the maids, who had various grievances, particularly with respect to housing. The strike lasted some 5 days, being terminated when the Board accepted a letter from the girls applying for reinstatement, expressing regret for their action, and pointing out that they would not have struck had they realized that they could have presented their grievances directly to the Board. Due to the overcrowding of the hospital and the inability to secure funds for building extensions during the past several years, the hospital has found considerable difficulty in providing adequate accommodation for nurses and staff. The Board is making further effort to see if funds can be obtained for new buildings.

* * *

ONTARIO.—The Premier of Ontario has made provision in the 1937 budget for an expenditure of $2,650,000 on the extension of mental hospitals, such will include a new mental hospital at Port Arthur. New buildings will be erected at Hamilton at a cost of $300,000, and at Woodstock the construction of two new units for epileptic children will be undertaken. The government will begin a programme of modernizing and fire-proofing at Brockville, Cobourg, Kingston, London, Hamilton, New Toronto, Orillia and Penetanguishene. It is the intention of the government that practically all of this work will be done by private contract for which tenders will be invited.

* * *

ONTARIO.—Plans for an extensive voluntary type of health insurance made further progress with the announcement by the President of the Ontario Medical Association that in three centres, Toronto, Windsor and Norfolk County, the insuring body, the Ontario Medical Services,

Inc., would be in operation in the near future. This will be a non-profit organization, operated by a joint medical and lay committee, and providing a full medical service including general practitioner and specialist care and hospital attention when required. Accurate statistics will be maintained and rates will be revised in the light of actual experience. If successful, it is anticipated that the plan will be adopted elsewhere and, in the minds of many of its supporters, may render unnecessary any compulsory plan.

* * *

OTTAWA.—The Department of National Defence has suggested to the various medical schools that medical students be trained in the methods of treatment of persons suffering from poison gas attack. This suggestion is now under advisement by the various medical faculties.

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QUEBEC.—The Honourable J. H. Paquette, Minister of Health for Quebec, speaking at the annual meeting of the Montreal Convalescent Hospital, assured the hospital of the willingness of the province to assist it in all its work, deplored the lack of convalescent homes, stating that further convalescent hospital provision might provide a provincial economy of as much as $1,000,000, and felt that convalescent hospitals served a vital need as adjuncts to the large hospitals. Sir Charles Lindsay hoped that the coming summer would see the beginning of work for a 100-bed extension to the hospital.

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WINNIPEG, MAN.—Doctor David A. Stewart, Superintendent of Ninette Sanatorium, and an international authority on tuberculosis, who died recently at the Winnipeg General Hospital, was one of the outstanding medical writers in this country. Interested as he was in literature,

(Continued on page 38)

biology, geology, and in etching, to mention but a few of his many hobbies, the many productions of his pen and stylus were a never-ending source of joy and delight to his wide circle of correspondents.

"These Be Your Kings" Recalls the Story of Britain's Monarchs

There has just been issued an attractively printed example of the printers' art, which has been designed to commemorate the Coronation to take place this year. As is implied in the title, this little volume recalls through the portals of historical fact, the story in abridged form, of Britain's monarchs during the past nine centuries.

"These Be Your Kings" has been produced by the Northern Electric Co., Limited, as a souvenir of the Coronation which, for the first time in history will be participated in by the whole world through the medium of the radio.

We do not know of any other means by which a person may so conveniently refresh himself in regard to intimate details in the lives of England's Kings, as well as of important events which occurred during their reign. This little booklet, we are sure, will be highly prized by all who are so fortunate as to receive a copy.

Consumers' Tax in Saskatchewan

Last minute press reports seem to indicate that a Consumers' Tax of two per cent is likely in Saskatchewan. This tax, if it becomes effective, will be used for educational purposes. If it follows along the lines recommended in the Jacoby Report which does not favour exemption in any form it will probably affect Saskatchewan hospitals to the extent of some $20,000 as their approximate purchases of commodities coming under this tax is in the neighbourhood of $1,000,000 annually. This unlooked-for expenditure will be quite serious for our hospitals which are at the present time endeavouring to make every dollar go as far as possible and even then find it difficult to make ends meet. It is anticipated that if this tax becomes effective and applies to hospital purchases that the Saskatchewan Hospital Association will immediately make overtures for exemption. By the time this notice appears we will definitely know whether the enactment has taken place or not.

Catholic Hospital Association Announces Two Conferences

Under the patronage of His Eminence, George Cardinal Mundelein, Archbishop of Chicago, and by the invitation of the Very Reverend Samuel K. Wilson, S.J., President of Loyola University, the Officers and Executive Board of the Catholic Hospital Association of the United States and Canada announces two Pre-Convention Conferences, the Conference on Hospital Administration, June 11th and 12th, and the Conference on Nursing Education, June 12th and 13th, 1937, at Loyola University, Sheridan Road, Chicago, Illinois.

Stamp Collectors Attention!

A letter has been received from England through the Secretarial offices of the Canadian Hospital Council asking for the names of any hospital administrators who are interested in used postage stamps. This enquiry comes from Mr. W. Read, Secretary, War Memorial Hospital, Bognar Regis, Sussex, England. Will any administrator interested in philatelics please write direct to Mr. Read, or if more convenient address your letter c/o the Editor of this Journal and we will see that it is forwarded?

New Appointment at Owen Sound General and Marine Hospital

Miss Pearl L. Morrison, formerly of the Sibley Memorial Hospital, Washington, D.C., has been appointed superintendent of the Owen Sound General and Marine Hospital, her duties commencing March 1st. Miss Morrison is a graduate of the Welland General Hospital and has had wide executive experience. She succeeds Miss B. Hall whose resignation took effect on February 1st.

Glace Bay Board Enlarged

The Constitution of St. Joseph's Hospital, Glace Bay, N.S., has been revised to permit the enlargement of the Board of Directors to comprise eighteen members. Eight will be elected at annual meetings to be held in the various parishes.

London Considering Group Hospitalization

The hospitals of London, Ontario, are giving consideration to the possibility of developing group hospitalization in that city.

Electrocardiograph for Oshawa

The Oshawa General Hospital is shortly to obtain an electrocardiograph.